



District 6  
Braai in Mitchell's Plain

**HEALTH CARE CHALLENGES CAPE TOWN, SOUTH AFRICA**  
2010 October - November  
Child Family Health International  
Rosen Trinidad

It's my first morning back from a two-month stay in Cape Town, South Africa. After I was picked up from Los Angeles International Airport, I dumped my duffle bags at home, grabbed my surfboard and headed for the beach. Most people have routines that help them clear their minds and organize their thoughts: a cup of coffee and the morning newspaper, a good book, painting, or a brisk jog around the block. For me it's always been the ocean. The waves were inconsistent, even in the secret spots, so I splayed out supine on my board, closed my eyes and drew in the warm southern California December sun. My finite presence drifting timelessly, bounded in the east by the sandy coastline and west by the pale blue horizon, gave me time to reflect on my experience in South Africa some ten thousand miles away.

My name is Rosen Trinidad. I just finished the second year of medical school in Oregon Health and Science University. After passing step 1 board test, I received a scholarship from Child Family Health International and took part in one of their many global health care education programs. I choose Health Care Challenges in Cape Town, South Africa primarily because of the nation's history. Although I read up on colonialism, the country's cultural demographics and reports from other CFHI students, the written word could not compare with the actual living and working in the cape flats and hospitals, or listening to the people's stories and finding humor even under the boot of apartheid.

I arrived in Cape Town on the second of October hauling luggage, some of which I would never use like malaria prophylactics, bug spray, box of gloves, and several ounces of hand sanitizer. The former two I would have needed if I traveled further east outside of Cape Town into Kruger National Park, and the latter were supplied, although sparingly, in the hospitals. Things I found useful to pack were first and foremost medical books and materials, especially those specific for my program, internal medicine at Victoria Hospital and orthopedic surgery at G.F. Jooste Hospital. Netter's Anatomy was obvious, but I would not have guessed Mostofi's Who's Who in Orthopedics would also come in handy. I brought a scalpel and suture kit, and practiced techniques on a foam board. Most homestays offered an abundant variety of meals; however, four-dozen protein bars prevented me from leaning out too much.

Finally, in order to function productively in Cape Town, there was something crucial I had to leave behind in the States: hubris and any grand illusions of saving poor African lives or expecting to find revelations in two months that would solve the complex problems facing an entire nation. More than anything, this served patients and me well. It's a mindset that literally opened doors for me to learn in the hospitals and build relationships throughout the diverse communities of Cape Town.

Aside from supplies and equipment, I flew into South Africa loaded with a slew of questions. Some were simply factual like the structure of health care while others required further evaluation especially on race relations and the distribution of wealth. CFHI coordinators Avril Whate and Marion Williams fetched me from the terminal, and on orientation day answered many of my questions.

Avril, CFHI medical director in Africa, summarized that the public health care under District Health System had substructures in eight metropolises divided by district and geographic boundaries. Each served up to half a million residents. Provisions for primary care, and most often the initial point of contact in the suburbs, were through eight-hour day hospitals. Twenty-four hour secondary hospitals for trauma and obstetric/gynecology emergencies included Victoria in Wynberg and G.F. Jooste in Manenberg. Tertiary hospitals provided specialist via referrals. Children under the age of thirteen were sent to the only dedicated pediatric hospital in South Africa, Red Cross War Memorial Children's Hospital. Adults were referred to Tygerberg Hospital in the east and Groote Shuur Hospital in the west. Anyone who claimed to be Capetonian would gladly point out that Groote Shuur was famous for the first successful human heart transplant.

The District Health System was established to address the discriminatory practices of health care delivery under apartheid. Sharing the piece of the pie brought about new financial and operational challenges, especially in face of the HIV/TB pandemic. Working in the hospitals, providers and administrative staff shed light on these concerns and some offered suggestions to resolve them.

There is a need for centralization and conversion of paper to computer based medical records, including lab and imaging studies. This would offer better assessment of patients' prognosis given an accurate and legible history. Centralized records prevent wasteful duplications of diagnostic tests. Intra or Internet capabilities would improve communication and data exchange between departments and other hospitals. Digital records would also free up hospital rooms allocated for data repositories.

Victoria and G.F. Jooste were not equipped with CT and MRI scans. Patients must be transported to and from Groote Shuur for these expensive imaging studies. Although million dollar machines are out of reach for the secondary hospitals, there maybe funding for less expensive technology like more ultrasound equipment in departments other than Ob/Gyn. This additional tool would provide better diagnosis, i.e. hydronephrosis, and increase the success rate of procedures from ultrasound guided supraclavicular brachial blocks to draining pericardial effusions.

In an abortion clinic, even with an amazing staff holding the fort, over fifty procedures a day can take its toll on the human spirit. Some patriarchal cultures have a great disdain for contraceptives, and my colleagues may see the same patients a couple months latter. Increase access to counseling, education in family planning or more economic opportunities for women can be neatly listed on paper, but long queues in the clinic can make anyone weary of the work.

Some of the limitations to reform were due to the economic burden of treating HIV/TB. In the internal medicine wards, a large percentage of beds and isolation rooms were dedicated to HIV/TB. There are organizations like UNAID and reputable journals that can describe in detail the widespread impact of AIDS/HIV in South Africa, where roughly eleven percent of the population or about five and half million are infected. If HIV/AIDS is the elephant in room, I can only provide a sketch of what its footprint may look like.

Visiting impoverished communities, I met people infected with HIV who readily disclosed their concerns. The government offers antiretroviral drugs and monetary assistance or grants depending on their CD4 counts. The loss of income from these grants as their CD4 count improved put them in a quandary: choose between long-term health or keep food on the table and a roof over their heads.

Even with all the necessary precautions and protocols in case of accidents, providers in the hospitals risk HIV exposure every time they admit a trauma patient, draw blood or operate in theater. The orthopedic surgeons I assisted approached all patients as though they had HIV. Like the prudent maintenance of a sterile field, safety becomes habitual. In fact, there was more consideration for someone immunocompromised to be able to endure the operation and recover without the complications of opportunistic infections.

In the midst of sparse resource springs forth ingenuity in the management of care and un-ebbing compassion towards patients. I spent the first month in Victoria Hospital, old Vic, located in Wynberg. Department head Dr. Clint Cupido introduced me to the practice of internal medicine in the Cape Flats. Lacking expensive tools like MRIs or CTs, doctors utilized their greatest assets; their own senses of sight, sound, touch and smell. My two years of didactic work coalesced into a few weeks by rounding with skilled physicians, developing a working knowledge of pathology, and performing thorough history and physical examinations (H&P).

Most of the internal medicine patients at Victoria presented in late stages of their disease. Compared to the States, there were a disproportionate number of young adults with terminal illness due primarily to HIV/TB. Exploring the wards on my first day, I came across a lethargic twenty-one year-old in acute respiratory distress with a history of lung disease and cor pulmonale. He was thin, lying in fetal position and grunting through an oxygen mask with every breath. I would find myself visiting daily. I was overjoyed to see him gradually improve to a point that he could talk about his girlfriend, finish off his meals and not leave a crumb on his plate. When I checked on him, he would grin, say “Sharp” and gave a thumbs-up or a Capetonian handshake.

Rounds began at eight in the morning for medical students with Residents presenting their patients to the Attending. Dr. Lindisa joined the internal medicine team on the same day I did and we developed a quick rapport. He had practiced family medicine for ten years in Qwazulu Natal, and decided to change specialties. Even with years of experience, you still feel nervous in a new environment. Following a train of white coats, I became familiar with each staff physician's unique style of teaching. Dr. van Zitter's enthusiasm in demonstrating a clinical finding was like being in the presence of Sherlock Homes just when he's about to solve a mystery. Dr. Abu entertained us with references on how to diagnose if all the machines broke down and all you had were your wits and a stethoscope. After rounding, we assisted Residents by completing technical duties like drawing blood, dropping lines or ordering labs. In the afternoon, there were lectures, bedside tutorials and time to hone our physical examination skills.

In the second week, medical students were assigned to follow patients and present their cases. Dr. Cupido asked me to follow a man in his sixties admitted to casualty with acute respiratory distress, supraventricular tachycardia, and insomnia. This was his second respiratory emergency in four weeks. He had a history of asthma, hypertension, chronic obstructive pulmonary disease, cor pulmonale, and polycythemia. The man drove himself to the hospital with his wife as passenger. This could have led to two patients admitted into casualty. History and labs suggested theophylline toxicity and after his respiratory distress was controlled he was given activated charcoal. His family visited in the evening and said he was in good spirits. I made my rounds in the morning and found white curtains drawn around my patient, instead of the usual green. I peel them back and saw the wife and daughter standing at the bedside being comforted by Sister Liz Pitout, a skilled palliative care nurse. My patient died in his sleep. As a prior EMT, it was not my first experience with death, but it still came as an awful surprise.

Afterwards, I would spend a few hours with Sister Pitout discussing Victoria Hospital's palliative care program: Abundant Life. It was born from an idea by a Resident who took up Dr. Cupido's challenge to find creative ways in managing the care of patients in the hospital. Abundant Life is the first program of its kind in South Africa. My patient was enrolled in the program. It utilized a holistic approach to organ failure by improving quality of life and minimizing financial loss. In fact, some patients with chronic renal failure, including a relative of Dr. Cupido, were able to find medical assistance for dialysis while enrolled in the program. Its operations and supplies were supported with money through fund-raisers coordinated by Barry Weber. Dr. Cupido later admitted to assigning me the sickest patient in the ward.

I was becoming comfortable with the setting and my duties in the hospital. It was intellectually satisfying to work through differential diagnosis with medical students from the University of Cape Town, UCT; sixth year students Tolgah and Moubiin and fourth year students Libeth, Danny, and Timber. My colleagues were equipped with dog-eared, rainbow-highlighted Oxford Internal Medicine Pocketbooks. We would spend hours mulling over cases or practicing physical examinations in the wards. If things were slow, I would join Natalie, a foreign medical student from Germany, and observed surgeries or admitted patients for operation.

Dr. Cupido stressed group cohesion. In my last week at Victoria, we had a team building activity of indoor soccer involving Clinicians, Residents, Barry and me. It was my first game of soccer, and I was flat footed. Basketball was my game and kicking the ball felt like a violation. My teammates fortunately had better offensive skills, so I tried to pull my weight in defense and assists.

On my final day at old Vic, I attended an Abundant Life counseling session facilitated by Dr. Cupido, Sister Pitout, and Barry Weber. I was dumbfounded to discover how many patients did not fully understand their disorder. Death was taboo. It wasn't necessarily denial, but most often ineffective communication. While Dr. Cupido was discussing the options of managing chronic renal failure to a patient, the twenty-one year old I met on my first day in the wards, with lung disease and cor pulmonale, was brought in on a gurney accompanied by his mother. He had required both a lung and heart transplant. Rather than announcing a death sentence, the Abundant Life program set out to make patients aware of their prognosis in plain language and options available in maintaining function and quality of life.

In November, I began my program in the orthopedic department at G.F. Jooste Hospital. Located in a sub-economic region of Manenberg, it served nearly half the population of Cape Town. A new secondary hospital being built in Mitchell's Plain would reduce the workload and waiting times. Currently, the orthopedic department had an estimated sixty patients a day in clinic and performed five to eight operations in theater. Dr. Paul Rowe headed the department. Rotating between other district hospitals, he spent two days of the week at Jooste working and teaching. Orthopedic Residents, Dr. Thomas Hilton and Dr. Anria Horn, alternated days between clinic and theater. POP (Plaster of Paris) technicians included Marion Mitchell, Reverend Lawrence, and Mr. Smith. Making everything run smoothly were the nursing staff: Sisters Mary Vryan, Christine, and Shereen in clinic and Sisters Jone and Elaine in theater. The place was kept immaculate by Danny, Louise, and Sharmaine.

On my first day, and after some detours, I arrived in the orthopedic clinic to find a short hallway lined with patients. They were sporting slings, plaster casts, and either on crutches or wheel chairs. It could have been a stressful environment working with such a large volume of restless patients. But that wasn't the case in Jooste's orthopedic department. I found Mitchell, the POP-tech expert, chatting up patients and easing tensions while Sister Mary called them in and kept a motherly eye out for those with more delicate conditions. On our first meeting, Mitchell, who had plaster residue caking his hands, looked me up and down surveying my nicely pressed white coat, fancy shirt, ironed slacks, and polished shoes. Then he asked, "Do you want to get dirty?" I knew then that I was going to love this place. I gave a big grin, took off my coat and threw on some scrubs.

I prepared for a day in the orthopedic department by studying musculoskeletal disorders and H&P the night before. By keeping record of the scheduled surgeries, I could review the relevant anatomy and the types of procedures that would be performed. The clinicians tested my knowledge and gave me direction on what topics to pursue. I became familiar with the common types of fractures seen in theater; Colles' I-VI, Smith's I-III, Monteggia I-IV, Garden I-IV, Schatzker I-VI, and Danis-Weber A-C. To observe and assist in

procedures, it was important for me to understand the theory and practical application of casts, external fixation with pins and wires, internal fixation with plates and screws, and intramedullary (IM) rods. I was also asked about historical figures in orthopedics. It was about respecting the pioneers who developed the awesome tools and techniques that we used in surgery, from intramedullary nailing by Dr. Kuntscher to iliac bone grafting by Dr. Rhinelander.



Mitchell at G.F. Jooste



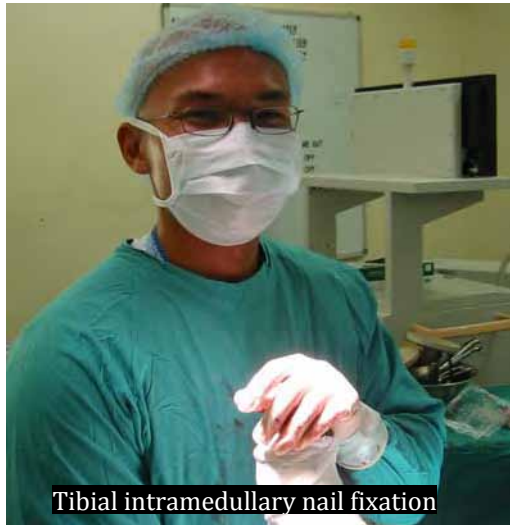
Commuting with Sisters

At seven in the morning, I began rounds and followed up on surgical patients with Dr. Anria Horn or Dr. Thomas Hilton. Sometimes I accompanied Mitchell, who on his own accord, would head to triage in search for orthopedic patients and facilitate their admission process. Manenberg was a poor suburb with a proliferation of crystal meth, locally called Tik because of the sound it made when smoked. Street gangs were in a violent competition for territorial control and distribution of Tik. The surviving product of community violence would end up in Jooste. There were always at least half a dozen stabbing victims, mostly young men, with pneumothorax being treated with chest tubes. I can recall one gang member who was high on Tik and kept emptying his chest tube bottle. It was a bloody mess. Beating victims, some battered with long plastic rods called sjambok, were provided fluid therapy and closely monitored for kidney function. They had a high risk of acute renal failure due to myoglobinuria and tubular necrosis. There would also be the occasional gunshot victim with fractures needing external fixation or open reduction internal fixation. By eight o'clock, I would head to the one of the two operating theaters.

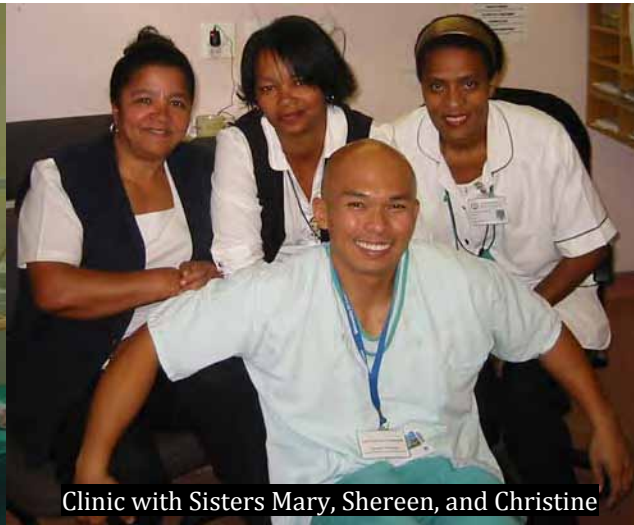
In the States, I have heard of stressful experiences that some medical students face during their surgical rotation. I asked Anria and Hilton how they managed medical school and residency. They followed simple, basic rules: don't brownnose, work hard, and enjoy your free time. I took their advice and ran with it.

Because I studied, I felt confident to assist during operations. Just by keeping the patients fingers extended, I could still watch and listen to Anria describe her techniques for the division of flexor retinaculum in carpal tunnel decompression. I provided an extra set of hands in reducing older fractures. They required aggressive manipulation due to the fact that after a couple of weeks the muscles adapt and shorten with the fractured extremity. I

marveled at the autologous bone-grafting operations like an iliac bone graft harvesting for a Schatzker type VI tibial plateau fracture. When I assisted in a modified Bristow procedure for anterior shoulder instability, I was amazed that bone with an attached muscle (coracoid process and minor pectoralis muscle) could be relocated to the anterior glenoid and be used as bone block. Through observations and independent studying, I was able to contribute more during the course of the program from working the diathermy and suturing to screwing in plates and reaming medullary cavities for IM rods.



Tibial intramedullary nail fixation



Clinic with Sisters Mary, Shereen, and Christine

I tried to make the surgical team's lives easier and at the same time learn as much as I could. When patients were brought into theater, I observed the anesthetists work their magic, providing suprascapular brachial blocks, spinal or general anesthesia. Then I would help OR nurse Noel, Sisters Jone and Elaine set up the sterile field as well as clean after the surgery. On one occasion, the fluoroscopy tech was delayed and I manned the cumbersome machine while Thomas gave me directions.

I would alternate days in either surgery or clinic. There was also time between operations to see patients, write admission and progress notes, or work in the POP room. Mary and Mitchell were the backbone of the clinic while the residents provided the muscle. In the POP room Mitchell and Mr. Smith taught me the art of making casts. Shaping the warm plaster to reduce fractures was like molding a clay pot. But instead of holding water and flowers, the final design was set to hold bone in proper alignment. There could be over sixty patients in clinic. With an efficient and dedicated team, we manage to see and treat everyone before the end of the day. There was even enough time for tea breaks and polite company. The great thing about working in the orthopedic department was the camaraderie. We all looked out for each other.

I made a lot of wonderful friends in Jooste and I was sad to leave. Out of respect for the patients and my colleagues, I didn't take photographs until the last day. It would have been disruptive having a stranger blind them with flashes or make them lose focus as they worked. In fact, photographs were discouraged at Victoria. It's also annoying and in some cases exploitive. But on the last day, I took the liberty of bringing my camera and shot photos of people I will genuinely miss. It's a shame that I couldn't fit them all in this report.

At Jooste, I was never idle. There was always something to do or someone new to meet. When I had spare time I would visit Estelle Peterson, coordinator of foreign medical students, or Judy Dudley, administrator of UCT students. Estelle gave me a unique point of view as a cancer survivor on how important tact is in relaying prognosis. The quickest way to lose trust and confidence was by giving an end date without being asked or discussing a patient's case during rounds as if they were just a disease and not a whole person. Estelle was soft spoken and one of the sweetest people I have met, but she has ferocity for life that kept her going despite all odds.



Lunch with Thomas and Anria

Visiting Estelle

Judy's office overlooked Manenburg with its rooftops of galvanized sheet-iron stretching out below. She and I discussed the history of Cape Town. Our talks were an extension of Marion William's meetings and Colleen's Cape Flats tour on race and culture. Citizens in Cape Town distinguish themselves as Coloured, Blacks, or Whites. The majority are Cape Coloured and proud of their heritage, an intermingling of indigenous Khoi and San tribes with settlers and slaves.

A concern universally raised, was the lack of historical appreciation by the new generation of Capetonians for the liberation movement. Western fashion and materialism predominated youth culture. From talks, I learned that some parents who were part of the liberation struggle were hesitant to politicize their children. With the increased economic mobilization, they were keener on providing their kids with a life style they themselves were denied. The Soweto uprising, the turning point in the liberation movement when thousands of students marched and twenty-three killed protesting policies of apartheid, seemed like a fading nightmare being pushed into the deepest recess of the subconscious.

Taking Anria and Thomas's advice, when I had free time I put my books away and explored Cape Town. On my first night in Africa, my homestay took me to Grandwest Casino. It was a huge facility housing tables, slots, restaurants, and a children's amusement park with an ice rink. It felt strange passing by the Langa shantytown to get there. However, it was one of the safest places at night for teenagers to congregate. Grandwest

also had a descent restaurant with live Jazz performers. I rented a car for thirty dollars a day and patronized the tourist sections of Cape Town's restaurants, bars, and nightclubs. The Waterfront, Long Street, Canal Walk, and Camps Bay were popular spots for vacationers. The Galaxy, a mostly Coloured nightclub, and Mzoli's Meat outdoor restaurants were places locals hung out. Not many former residents of District 6 went to the Waterfront. In order to build the tourist attraction, the mostly Colored residents of District 6 were forcibly relocated and racially segregated into townships.

If I wanted to appreciate the scenery and watch life pass me by, I would have gone to The Gardens, Table Mountain, or Cape Point. I could enjoy Nature's beauty and stay active at the same time by heading out to the beach breaks of Muizenburg and go surfing. The first thing that caught my eye was a menacing black flag with a white outline of a great white, a daily warning of the shark infested water. There were always boats and helicopters monitoring for predators and plenty of swimmers to provide a margin of safety. The only thing that would deter me from surfing was the howling Cape Town wind that blew out the waves into boiling and churning water.

I spent time wandering my homestay's neighborhood, Vanguard, a middle income colored community. Across Klipfontein Road, I joined a Virgin health club where I met an assortment of characters from rugby players and martial arts experts, to Dr. van As: head of Pediatric Surgery at Red Cross War Memorial Children's Hospital. I was even invited to round with the good doctor. After gyming, as they called it, I would usually grab a Cape Town style hoagie from Golden Plate. The full house special was a sandwich of fries, eggs, and tender beef. It weighed about five pounds and would last me for a few days.

Witnessing the result of community violence, approach of death and the constant misery of poverty can test one's faith. A neighbor, Mrs. Wakefield, introduced me to St. Theresa's Catholic Church, located in Welcome Estate. It was a short ways from my Vanguard homestay, and I would walk with Mrs. Wakefield once a week to attend morning mass.



By getting to know the people at work, I was able to become part of the greater community outside the hospital. I even found someone who would rent a car for ten dollars a day without charging damage liability. On my last week in South Africa, Sister Mary Vryan invited me to stay at her home in Mitchell's Plain. It was a Coloured working-class neighborhood with a fifteen-minute walk to the Indian Ocean. I met Bianca, Mary's daughter, and Courtney Sacco, a police officer. They welcomed me into their house as if I was a long lost relative. Their friends became mine: Kenny, Patrick, Vanessa, Boute, Domi,

Abigail, John, Pamela, Edgar, and George. By introducing me to their neighbors, I could walk with ease in Mitchell's Plain.

On Sundays, they held organized neighborhood soccer matches with several teams competing for a cash prize. There would be over a hundred people lining the field, cheering and enjoying the company. Recalling my first game of indoor soccer, I gladly turned down a request to join Courtney's team. Most of the players were teenagers and they took their game seriously.

Instead, I accepted an offer to go surf fishing in the evening. It was a technical process: the attachment of bait and sinker, operation of the reel and proper thumb placement, and finally surfcasting and reeling-in fish. After a couple of hours, we only caught and released a pair of sand sharks. Nonetheless, it was still a beautiful evening. The fierce off shore winds died down by midnight. With sounds of waves tumbling on each other, I was wrapped in the cool moonless night, showered by millions of stars.

A traditional braai, or barbeque party in Afrikaans, was held for me on my first as well as my last night in Mitchell's Plain. Courtney and Kenny prepared the drum braai. It was a long ritual that began at noon with the kindling of chopped wood, old coals, plastic and fuel pellets. By evening the red glowing embers peered through white crusts of ash, like nocturnal wolves' eyes eager for a meal. Mary and Bianca marinated chicken, beef, and pork ribs in masala sauce and along with boerewors (Afrikaans sausage) placed them in a steel meshwork ready for the men to braai. Friends arrived with contributions to the social and the jol (party) would start with music, food and dancing. It wouldn't end until the wee hours of the following day.



Kenny and Courtney man the Braai

Bianca, Vanessa, Mary, Courtney, and little Brooklyn

There were plenty of things to do in South Africa: jump off bridges, ride ostriches, pet elephants, explore caves, swing through treetops, or swim with sharks. But nothing beats a good braai. The traditional South African food with family and close friends more than made up for missing Thanksgiving in the States. On November 28, Mary and a company of cars took me to the airport and bid me a safe journey.

I returned to Los Angeles with a clearer view of my professional career and a better understanding of Cape Town culture. Working hard and enjoying every minute of it, I was accepted with open arms by the communities I served. I would like to thank CFHI for giving me the opportunity to visit South Africa and also Dr. Scott Fields and Dr. Jeremy Holden for their recommendations. Most of all, thanks to my new friends for welcoming me at work and in their homes. I had a jol in Cape Town.



Bungee off Bloukrans Bridge



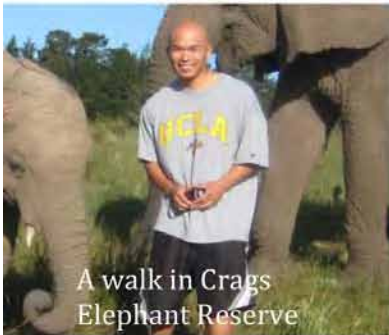
Exploring Cango Caves



A Race at the Cango Ostrich Ranch



Swing through the canopy of Tsitsikamma National Park



A walk in Craggs Elephant Reserve



Cage shark diving off Dyer Island



Inspecting the vineyards of the Cape Winelands